NEVADA STATE BOARD OF MEDICAL EXAMINERS
APPLICATION FOR PRACTITIONER OF RESPIRATORY CARE LICENSURE
FEE SCHEDULE FOR JULY 1, 2013 THROUGH JUNE 30, 2015

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½" x 11" in size.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

Fees applicable July 1, 2013 – June 30, 2014:

$100 Application Fee $200 Registration Fee $75 Criminal Background Investigation Fee = $375.00

Fees applicable July 1, 2014 – June 30, 2015:

$100 Application Fee $100 Registration Fee $75 Criminal Background Investigation Fee = $275.00

You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

The Application fee and Criminal Background Investigation fee will not be refunded.

PLEASE NOTE:

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

If, at the time you meet with the Board, the Board votes to deny or **not** accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the National Board for Respiratory Care, Inc., or its successor organization.

If the practitioner of respiratory care applicant has not practiced as a practitioner of respiratory care for 12 months or more before applying for licensure in this state, he or she may, at the order of the Board, be required to take and pass such examination to test professional competency as the Board shall deem appropriate.

The practitioner of respiratory care applicant must be able to communicate adequately, both orally and in writing, in the English language. The practitioner of respiratory care applicant must be of good moral character and reputation. If a licensee loses certification by the National Board of Respiratory Care, Inc., or its successor organization, his or her license to practice respiratory care in Nevada is automatically suspended until further order of the Board. The practitioner of respiratory care shall immediately notify the Board of termination of employment as a practitioner of respiratory care. The practitioner of respiratory care shall submit to the Board a summary of the reasons for and circumstances of the termination of employment.

Practitioner of respiratory care licenses will be issued in the applicant's name as indicated on the submitted documentation for proof of such name (i.e., U.S. birth certificate, Certificate of Naturalization or Alien Registration card).

Grounds for rejection of an application for practitioner of respiratory care licensure:

If it appears that:

1. An applicant for licensure as a practitioner of respiratory care is not qualified or is not of good moral character or reputation;
2. Any credential submitted is false; or
3. The application is not made in proper form or other deficiencies appear in it, the application may be rejected.

NRS 630.277 Requirements; prohibitions; intern in respiratory care.

1. Every person who wishes to practice respiratory care in this State must:

(a) Have a high school diploma or general equivalency diploma;

(b) Complete an educational program for respiratory care which has been approved by the Commission on Accreditation of Allied Health Education Programs or its successor organization or the Committee on Accreditation for Respiratory Care or its successor organization;

(c) Pass the examination as an entry-level or advanced practitioner of respiratory care administered by the National Board for Respiratory Care or its successor organization;

(d) Be certified by the National Board for Respiratory Care or its successor organization; and

(e) Be licensed to practice respiratory care by the Board and have paid the required fee for licensure.

2. Except as otherwise provided in subsection 3, a person shall not:

(a) Practice respiratory care; or

(b) Hold himself or herself out as qualified to practice respiratory care,

➥ in this State without complying with the provisions of subsection 1.

3. Any person who has completed the educational requirements set forth in paragraphs (a) and (b) of subsection 1 may practice respiratory care pursuant to a program of practical training as an intern in respiratory care for not more than 12 months after completing those educational requirements.

NAC 630.500 Qualifications of applicants.

An applicant for licensure as a practitioner of respiratory care must have the following qualifications:

1. If he has not practiced as a practitioner of respiratory care for 12 months or more before applying immediately preceding his application for licensure in this State, he must, except as otherwise provided in subsections 2 and 3, at the order of the Board, take and pass [an] any examination that the Board deems appropriate to test the professional competency of the practitioner.

2. If he has not practiced as a practitioner of respiratory care for 12 months or more but less than 5 years immediately preceding his application for licensure in this State, he may provide proof that he has successfully completed 10 units of continuing education for each year or portion thereof he has not practiced respiratory care. If he provides proof of successfully completing at least 10 units of continuing education for each year or portion thereof he has not practiced respiratory care, he is exempt from the examination required pursuant to subsection 1.

3. If he has not practiced as a practitioner of respiratory care for 5 years or more immediately preceding his application for licensure in this State, he must retake and pass the examination required to be certified as a practitioner of respiratory care administered by the National Board for Respiratory Care or its successor organization.

4. Be able to communicate adequately orally and in writing in the English language.

5. Be of good moral character and reputation.

6. Be in compliance with the provisions of NRS 630.277.

NAC 630.505 Application for license. (NRS 630.130, 630.279)

1. An application for licensure as a practitioner of respiratory care must be made on a form supplied by the Board. The application must include:

(a) The date of birth and the birthplace of the applicant, his or her sex and the various places of his or her residence after reaching 18 years of age;

(b) The education of the applicant, including, without limitation, all high schools, postsecondary institutions and professional institutions attended, the length of time in attendance at each high school or institution and whether he or she is a graduate of those schools and institutions;

(c) Whether the applicant has ever applied for a license or certificate as a practitioner of respiratory care in another state and, if so, when and where and the results of his or her application;

(d) The professional training and experience of the applicant;

(e) Whether the applicant has ever been investigated for misconduct as a practitioner of respiratory care or had a license or certificate as a practitioner of respiratory care revoked, modified, limited or suspended or whether any disciplinary action or proceedings have ever been instituted against him or her by a licensing body in any jurisdiction;

(f) Whether the applicant has ever been convicted of a felony or an offense involving moral turpitude;

(g) Whether the applicant has ever been investigated for, charged with or convicted of the use, illegal sale or distribution of controlled substances; and

(h) A public address where the applicant may be contacted by the Board.

2. An applicant must submit to the Board:

(a) Proof of completion of an educational program as a practitioner of respiratory care that is approved by the Commission on Accreditation of Allied Health Education Programs or its successor organization or the Committee on Accreditation for Respiratory Care or its successor organization;

(b) Proof of passage of the examinations required by NRS 630.277 and NAC 630.500 and 630.515; and

(c) Such further evidence and other documents or proof of qualifications as required by the Board.

3. Each application must be signed by the applicant and sworn to before a notary public or other officer authorized to administer oaths.

4. The application must be accompanied by the applicable fees for the application for licensure and biennial registration.

5. An applicant shall pay the reasonable costs of any examination required for licensure.

NAC 630.540 Grounds for discipline or denial of licensure.

A practitioner of respiratory care is subject to discipline or denial of licensure by the Board if, after notice and hearing in accordance with this chapter, the Board finds that the practitioner of respiratory care:

1. Willfully and intentionally made a false or fraudulent statement or submitted a forged or false document in applying for a license or renewing a license.

2. Performed respiratory care services other than as permitted by law.

3. Committed malpractice in the performance of respiratory care services, which may be evidenced by claims settled against a practitioner of respiratory care.

4. Disobeyed any order of the Board or an investigative committee of the Board or violated a provision of this chapter.

5. Is not competent to provide respiratory care services.

6. Lost his or her certification by the National Board for Respiratory Care or its successor organization.

7. Failed to notify the Board of loss of certification by the National Board for Respiratory Care or its successor organization.

8. Falsified records of health care.

9. Rendered respiratory care to a patient while under the influence of alcohol or any controlled substance or in any impaired mental or physical condition.

10. Practiced respiratory care after his or her license has expired or been suspended.

11. Has been convicted of a felony, any offense involving moral turpitude or any offense relating to the practice of respiratory care or the ability to practice respiratory care.

12. Has had a license to practice respiratory care revoked, suspended, modified or limited by any other jurisdiction or has surrendered such license or discontinued the practice of respiratory care while under investigation by any licensing authority, a medical facility, a branch of the Armed Forces of the United States, an insurance company, an agency of the Federal Government or any employer.

13. Engaged in any sexual activity with a patient who is currently being treated by the practitioner of respiratory care.

14. Engaged in disruptive behavior with physicians, hospital personnel, patients, members of the family of a patient or any other person if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.

15. Engaged in conduct that violates the trust of a patient and exploits the relationship between the practitioner of respiratory care and the patient for financial or other personal gain.

16. Engaged in conduct which brings the respiratory care profession into disrepute, including, without limitation, conduct which violates any provision of a national code of ethics adopted by the Board by regulation.

17. Engaged in sexual contact with a surrogate of a patient or other key person related to a patient, including, without limitation, a spouse, parent or legal guardian, that exploits the relationship between the practitioner of respiratory care and the patient in a sexual manner.

18. Made or filed a report that the practitioner of respiratory care knows to be false, failed to file a record or report as required by law or willfully obstructed or induced another to obstruct such filing.

19. Altered the medical records of a patient.

20. Failed to report any person that the practitioner of respiratory care knows, or has reason to know, is in violation of the provisions of chapter 630 of NRS or NAC 630.500 to 630.560, inclusive, relating to the practice of respiratory care.

21. Has been convicted of a violation of any federal or state law regulating the prescription, possession, distribution or use of a controlled substance.

22. Held himself or herself out or permitted another to represent him or her as a licensed physician.

23. Violated any provision that would subject a practitioner of medicine to discipline pursuant to NRS 630.301 to 630.3065, inclusive, or NAC 630.230.

PRACTITIONER OF RESPIRATORY CARE

APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

_____	a.	APPLICATION: ☐ Properly completed, signed and notarized application, including pages 1 – 4, Applicant Responsibility statement, and Criminal Background Investigation report authorization form; ☐ Recent passport quality photograph (at least 2"x 2") attached to application, signed in ink on lower front edge; ☐ Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 13, 14, 20, 21, 22, 23, 24, and 25; ☐ For affirmative responses, please include copies of documentation from courts or other entity, if applicable; ☐ Release form - signed and notarized (Form A);
_____	b.	FEES: • Proper application, registration, AND criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. Note: Application and criminal background investigation fees are <u>non</u>-refundable;
_____	c.	IDENTITY (Important identity documents will be returned to you via secured mail): • U.S. born citizens – Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable); • Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport; • Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;
_____	d.	EDUCATION: ☐ Copy of high school transcripts, diploma, or general equivalency diploma showing graduation date; ☐ Copy of transcripts or diplomas for degrees other than Respiratory Care degree – Associates, Bachelors or Masters Degree that you would like added to your educational profile on the Board's website;

<u>TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN TO BOARD OFFICE</u>:

(Verifying agencies may charge a fee.)

Do not provide pre-stamped or pre-addressed envelopes.

_____	a.	PRACTITIONER OF RESPIRATORY CARE SCHOOL: ☐ Verification of completion of Practitioner of Respiratory Care Education (Form 1); ☐ Official transcripts from Practitioner of Respiratory Care school;
_____	b.	EXAMINATION: • Current certification by the National Board for Respiratory Care, Inc. (Form 2), or its successor organization (applicant may request this online: www.nbrc.org);
_____	c.	STATE LICENSE VERIFICATIONS: • Verification of licensure from ALL states where applicant is currently licensed or has ever been licensed (Form 3) [does not include training licenses or temporary permits];
_____	d.	FINGERPRINTS: • FBI Criminal history background report – returned directly by the verifying institution to the Board office. **(Once application fees have been received, a fingerprint card and instructions will be mailed to the applicant. Note: The Board fingerprint card contains the necessary Board account numbers required for processing.)**

ATTENTION APPLICANT!
RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during your training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

○ ○ ○ ○ ○

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

7/1/2013 – 6/30/2015

PRACTITIONER OF RESPIRATORY CARE APPLICATION FOR LICENSURE NEVADA STATE BOARD OF MEDICAL EXAMINERS

Date Received by Board

License No._____

File No._____

(For Board Use Only)

P.O. Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Ste. 301 Reno, Nevada 89502

1. Present Legal Name _____
Last First Middle Maiden

List any other name ever used _____

Address:

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address _____
Street City County State Zip

☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers _(____)_____ _(____)_____ _(____)_____ _(____)_____
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth _____ Place of Birth _____ Gender___F___M
Month / Day / Year (City / State / Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____ Visa _____

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number _____ Height _____ Weight _____ Color of Eyes _____ Color of Hair _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice as a practitioner of respiratory care shall include the social security number of the applicant in the application submitted to the Board.
NAC 630.505(2)(c) The applicant must submit to the Board such further evidence and other documents or proof of qualifications as required by the Board.

The "practice of respiratory care" includes:

1. **Therapeutic and diagnostic use of medical gases, humidity and aerosols and the maintenance of associated apparatus;**
2. **The administration of drugs and medications to the cardiopulmonary system;**
3. **The provision of ventilatory assistance and control;**
4. **Postural drainage and percussion, breathing exercises and other respiratory rehabilitation procedures;**
5. **Cardiopulmonary resuscitation and maintenance of natural airways and the insertion and maintenance of artificial airways;**
6. **Carrying out the written orders of a physician, physician assistant, certified registered nurse anesthetist or an advanced practitioner**
7. **of nursing relating to respiratory care;**
8. **Techniques for testing to assist in diagnosis, monitoring, treatment and research related to respiratory care, including the**
9. **measurement of ventilatory volumes, pressures and flows, collection of blood and other specimens, testing of pulmonary functions**
10. **and hemodynamic and other related physiological monitoring of the cardiopulmonary system; and**
11. **Training relating to the practice of respiratory care.**

For the purposes of the following questions, these phrases or words have these meanings:

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber□s direction.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition that in any way impairs or limits your ability to provide respiratory care services with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

9. If you currently have a medical condition which in any way impairs or limits your ability to provide respiratory care services, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to provide respiratory care services with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.)

_____Yes _____No _____N/A

11. Have you EVER been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice), including any military tort claims, if applicable? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

12. Have you had a professional liability (malpractice) claim paid on your behalf, or paid such a claim yourself (including any military tort claims if applicable)? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

14. Have you previously applied for an allied health license in Nevada? (This does not include Blood Gas Licenses). _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

15. List all schools attended in **chronological order** including high school, college and/or university, and Practitioner of Respiratory care education. Please show dates of attendance in months and years:

School Name	City/State	Type of Degree / Major Received	Dates of Attendance From (mo/yr)	To (mo/yr)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Respiratory Degree granted by:

Respiratory School	City / State	Exact Date of Issuance

17. List briefly all activities in **chronological order** since graduation from respiratory school: (ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.)

City / State / Country	Activity	From (mo/yr)	To (mo/yr)

(All information must begin on the application. If more space is needed, please attach separate sheet)

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a respiratory therapist in any state or territory.

State/Territory	License #	Date of Issuance (Mo/Yr)	Date of Expiration (Mo/Yr)

(All information must begin on the application. If more space is needed, please attach separate sheet)

19. Are you currently certified by and/or registered with the National Board for Respiratory Care? _____Yes _____No

If "No", Date scheduled to sit for the exam: _____

Expiration Date: _____
(For those who are certified or registered after 7/1/2002)

If you are an RRT, provide Registration number: _____

20. Have you ever been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

21. Have you ever had a certificate or license to provide respiratory care services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

22. Have you ever voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

23. Have you ever failed the National Board for Respiratory Care examination, or any state or other jurisdiction examination for certification, licensure or registration? If your answer is "yes", give details regarding how many times you failed, including dates and the reason(s) you believe you failed the examination(s). Sign your explanation. (If "Yes," attach explanation on separate sheet.) _____Yes _____No

24. Have you ever had your registration/certification revoked, suspended and/or limited by the National Board for Respiratory Care? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

25. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a provider of respiratory care by any licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order;

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. _____Yes _____No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX (6) MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six (6) months.

_____ _____

Signature of applicant **Date**

APPLICATION AFFIRMATION

I, _____**,**

(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

_____ _____

Signature of applicant **Date**

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____

City State

_____

Signature of Notary

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing board any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

A photocopy of this form will serve as an original.

Please return completed form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301, Reno, NV 89502
or
P.O. Box 7238
Reno, NV 89510

FORM 1

PRACTITIONER OF RESPIRATORY CARE
EDUCATION VERIFICATION

This certifies that: _____
(printed name of applicant)

DOB:_____ SSN: _____

The following information to be completed by program only.

was enrolled in: _____
(name of school / name of respiratory care program)

located at: _____
(address of practitioner of respiratory care program)

from: _____ to: _____
(dates of attendance – month/year) (dates of attendance – month/year)

The applicant successfully completed their respiratory care practitioner training program on

the _____ day of _____, _____.
(date) (month) (year)

Signed and the seal affixed this _____ day of

_____, 2_____.

(Affix Seal Here)

By _____
(Typed name and title of President, Dean or Registrar)

Title_____

Signature _____
(Signature of President, Dean or Registrar)

**** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.**

Completed form is to be returned by verifying program directly to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301
Reno, NV 89502

FORM 2

The National Board for Respiratory Care, Inc.
18000 W. 105th Street
Olathe, Kansas 66061-7543
(913) 895-4900

Part 1 - *to be completed by applicant*

Printed name of applicant: _____
And / or social security number: _____

I am in the process of applying for practitioner of respiratory care licensure in the state of Nevada. I hereby authorize release of the information, requested in Part 2 below, directly to the Nevada State Board of Medical Examiners.

Signature of applicant: _____

*You must include check or money order in the amount of $5.00 made payable to the NBRC. (If you are not an active member, the fee is $20.00.)

Part 2 - *to be completed by The National Board for Respiratory Care, Inc. and RETURNED DIRECTLY TO THE OFFICE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS (Applicant may request this verification online: www.nbrc.org (under the 'Credentialed Practitioners' link))*

I certify that _____
(Name of applicant)

was granted initial certification/registration by The National Board for Respiratory Care, Inc. on:

Date issued: _____

Certificate/Registration Number: _____

The above-referenced certificate/registration is: _____ Current, in good standing
_____ Not current

Expiration date of current certification/registration: _____

Signature and title of certifying individual:

_____ _____
(date)

Completed form is to be returned by The National Board for Respiratory Care, Inc. directly to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301
Reno, NV 89502

__Applicant__: ***Each state where licensure/certification __is or ever was__ held must complete this form. If more than one state, photocopies of this blank form may be made and used. You may want to contact the state(s) where you were licensed since some states charge a fee for license verifications and some do not. The direct-source verification of your license does not have to be completed on this form. It is a courtesy form which provides the Board's address.***

FORM 3

PRACTITIONER OF RESPIRATORY CARE STATE CERTIFICATION/REGISTRATION VERIFICATION

Part 1 - *to be completed by applicant*

Printed name of applicant: ____

Date of birth of applicant: ____

I am applying for practitioner of respiratory care licensure in the state of Nevada. I hereby authorize release of the information, requested in Part 2 below, directly to the Nevada State Board of Medical Examiners.

Signature of applicant: ____

- -

Part 2 - *to be completed by each state and RETURNED DIRECTLY TO THE OFFICE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS*

I certify that ____
(name of applicant)
was granted certificate/license # ______________________ on ______________________
(date issued)
by the state of ____

on the basis of ____ .
(The National Board for Respiratory Care, Inc. - state examination - other)

The above-referenced certificate/license is:

_______ Current, in good standing _______ Not current, due to non-payment of fees

_______ Other (please attach explanation)

Expiration date of current certificate/license: ________________________________

I certify that the records in this office indicate that there are not now nor have there ever been any disciplinary action filed against the holder of this certificate/license. (If disciplinary action has been filed, __please attach an explanation__.)

Signature and title of certifying individual:

____ ______________
(date)

Completed form is to be returned by certifying/licensing state directly to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301
Reno, NV 89502

PERMISSION TO SEEK
CRIMINAL BACKGROUND INVESTIGATION REPORT
AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to Nevada Revised Statutes Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this _____ day of _____, 2_____.

_____

Signature of Applicant

_____

Print Name

By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action, up to and including immediate summary suspension of my license. NRS 630.167.

_____

Signature of Applicant **Date**

Return this form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301, Reno, NV 89502
or
P.O. Box 7238
Reno, NV 89510

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510-7238
or fax to:
775-688-2321

***Please type or print legibly*.**

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____